FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026914

Facility Name: CONCORD EXTENDED CARE

Address: 9401 SOUTH RIDGELAND (Number) OAK LAWN (City) 60453 (Zip Code)

County: COOK

Telephone Number: 708-449-9090 **Fax #** 708-449-7070

IDPA ID Number: 36-2833027

Date of Initial License for Current Owners: 1967

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	EDWARD N. SLACK, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	49,044	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	49,044	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,507	294	3,504	8,305	8
9	SNF/PED					9
10	ICF	22,002	14,408	195	36,605	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,509	14,702	3,699	44,910	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.57%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1962

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 2,920

Medicare Intermediary AdminaStar

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	178,381	23,390	13,614	215,385		215,385	(712)	214,673			1
2	Food Purchase		169,754		169,754	(16,397)	153,357	683	154,040			2
3	Housekeeping	198,036	37,074		235,110		235,110	1,595	236,705			3
4	Laundry	73,907	12,327		86,234		86,234		86,234			4
5	Heat and Other Utilities			87,318	87,318		87,318	1,223	88,541			5
6	Maintenance	38,514		67,037	105,551		105,551	7,616	113,167			6
7	Other (specify):*							1,632	1,632			7
8	**TOTAL General Services**	488,838	242,545	167,969	899,352	(16,397)	882,955	12,037	894,992			8
	B. Health Care and Programs											
9	Medical Director			5,171	5,171		5,171		5,171			9
10	Nursing and Medical Records	1,429,385	53,776	180,151	1,663,312		1,663,312	5,013	1,668,325			10
10a	Therapy	47,737	1,960	7,106	56,803		56,803	(285)	56,518			10a
11	Activities	75,681	6,766	4,473	86,920		86,920	(559)	86,361			11
12	Social Services	48,511		1,152	49,663		49,663	(2,016)	47,647			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,768	4,768			15
16	**TOTAL Health Care and Programs**	1,601,314	62,502	198,053	1,861,869		1,861,869	6,921	1,868,790			16
	C. General Administration											
17	Administrative			224,429	224,429		224,429	25,800	250,229			17
18	Directors Fees											18
19	Professional Services			255,978	255,978	(6,757)	249,221	(199,121)	50,100			19
20	Dues, Fees, Subscriptions & Promotions			52,098	52,098		52,098	(36,724)	15,374			20
21	Clerical & General Office Expenses	92,685	15,894	97,032	205,611		205,611	13,276	218,887			21
22	Employee Benefits & Payroll Taxes			319,805	319,805	16,397	336,202	(20,668)	315,534			22
23	Inservice Training & Education			2,670	2,670		2,670		2,670			23
24	Travel and Seminar			5,647	5,647		5,647	3,548	9,195			24
25	Other Admin. Staff Transportation			5,673	5,673		5,673	(5,234)	439			25
26	Insurance-Prop.Liab.Malpractice			60,095	60,095		60,095	815	60,910			26
27	Other (specify):*							24,323	24,323			27
28	**TOTAL General Administration**	92,685	15,894	1,023,427	1,132,006	9,640	1,141,646	(193,985)	947,660			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,182,837	320,941	1,389,449	3,893,227	(6,757)	3,886,470	(175,028)	3,711,442			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CONCORD EXTENDED CARE
0026914
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	16,397	
2	FOOD		16,397

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	6,757	
19	PROFESSIONAL FEES		6,757

To reclass cost of appealing real estate taxes

Facility Name & ID Number CONCORD EXTENDED CARE #0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			127,775	127,775		127,775	(392)	127,383			30
31	Amortization of Pre-Op. & Org.			2,219	2,219		2,219		2,219			31
32	Interest			87,080	87,080		87,080	1,591	88,671			32
33	Real Estate Taxes			142,724	142,724	6,757	149,481	1,657	151,138			33
34	Rent-Facility & Grounds							3,168	3,168			34
35	Rent-Equipment & Vehicles			4,862	4,862		4,862	2,612	7,474			35
36	Other (specify):*											36
37	**TOTAL Ownership**			364,660	364,660	6,757	371,417	8,636	380,053			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,713	170,657	251,370		251,370	(4,075)	247,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,566	73,566		73,566		73,566			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		80,713	244,223	324,936		324,936	(4,075)	320,861			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,182,837	401,654	1,998,332	4,582,823		4,582,823	(170,467)	4,412,356			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,947)	30		9
10	Interest and Other Investment Income	(7,675)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(549)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,930)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	21		24
25	Fund Raising, Advertising and Promotional	(23,469)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,700)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,934)	20		28
29	Other-Attach Schedule	(3,705)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,909)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(58,558)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,558)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (170,467)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CONCORD EXTENDED CARE

ID# 0026914

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Misc. Income - Jury Duty	(17)	10	2
3	Collection Expense	(2,534)	21	3
4	Bank Charges	(970)	21	4
5	C.O.P.E. Contribution	(184)	20	5
6				6
7				7
8				8
9				9
10				10
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87				87
88				88
89				89
90	Total	(3,705)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			3,805	(4,854)		337						(712)	1
2	Food Purchase	(549)		(809)			2,041						683	2
3	Housekeeping			1,595									1,595	3
4	Laundry													4
5	Heat and Other Utilities			1,223									1,223	5
6	Maintenance			10,011	(2,404)		9						7,616	6
7	Other (specify):*			1,532			100						1,632	7
8	**TOTAL General Services**	(549)		17,357	(7,258)		2,487						12,037	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)		19,310	(20,068)	10,287	1		(4,501)				5,013	10
10a	Therapy			3,730	(4,015)								(285)	10a
11	Activities			1,618	(2,177)								(559)	11
12	Social Services			1,426	(3,442)								(2,016)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,328		1,440							4,768	15
16	**TOTAL Health Care and Programs**	(17)		29,412	(29,702)	11,727	1		(4,501)				6,921	16
	C. General Administration													
17	Administrative			25,747	(82,411)	82,411	53						25,800	17
18	Directors Fees													18
19	Professional Services	(13,930)		6,779	(191,986)		16						(199,121)	19
20	Fees, Subscriptions & Promotions	(25,587)		995	(12,136)		4						(36,724)	20
21	Clerical & General Office Expenses	(55,204)		91,697	(23,270)		53						13,276	21
22	Employee Benefits & Payroll Taxes				(20,668)								(20,668)	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,545			3						3,548	24
25	Other Admin. Staff Transportation			158	(5,484)		92						(5,234)	25
26	Insurance-Prop.Liab.Malpractice			815									815	26
27	Other (specify):*			13,547		10,776							24,323	27
28	**TOTAL General Administration**	(94,721)		143,283	(335,955)	93,187	221						(193,985)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,287)		190,052	(372,916)	104,914	2,709		(4,501)				(175,028)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(8,947)		8,555									(392)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,675)		9,263			3						1,591	32
33	Real Estate Taxes			1,657									1,657	33
34	Rent-Facility & Grounds			3,168									3,168	34
35	Rent-Equipment & Vehicles			2,607			5						2,612	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(16,622)		25,250			8						8,636	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(4,075)						(4,075)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**						(4,075)						(4,075)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,909)		215,302	(372,916)	104,914	(1,358)		(4,501)				(170,467)	45

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 4,854	CARE CENTERS, INC.	100.00%	$ 0	$ (4,854)	15
16	V	19	ACCOUNTING	15,000	CARE CENTERS, INC.		0	(15,000)	16
17	V	19	ANCIL ADMIN FEE	15,960	CARE CENTERS, INC.		0	(15,960)	17
18	V	19	BOOKEEPING	27,132	CARE CENTERS, INC.		0	(27,132)	18
19	V	19	DATA PROCESSING	4,788	CARE CENTERS, INC.		0	(4,788)	19
20	V	19	LEGAL	12,136	CARE CENTERS, INC.		0	(12,136)	20
21	V	19	MANAGEMENT FEE	111,720	CARE CENTERS, INC.		0	(111,720)	21
22	V	19	PROFESSIONAL FEES	5,250	CARE CENTERS, INC.		0	(5,250)	22
23	V	20	ADVERTISING	12,136	CARE CENTERS, INC.		0	(12,136)	23
24	V	25	REBILL BUS	5,484	CARE CENTERS, INC.		0	(5,484)	24
25	V	0			CARE CENTERS, INC.		0		25
26	V	22	HOME OFFICE PAYROLL TAX	20,668	CARE CENTERS, INC.		0	(20,668)	26
27	V	1	REBILL. PAYROLL DIETARY	0	CARE CENTERS, INC.		0		27
28	V	3	REBILL. PAYROLL HSKPNG	0	CARE CENTERS, INC.		0		28
29	V	6	REBILL. PAYROLL MAINT.	2,404	CARE CENTERS, INC.		0	(2,404)	29
30	V	10	REBILL. PAYROLL NURSING	20,068	CARE CENTERS, INC.		0	(20,068)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,015	CARE CENTERS, INC.		0	(4,015)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	2,177	CARE CENTERS, INC.		0	(2,177)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	3,442	CARE CENTERS, INC.		0	(3,442)	33
34	V	17	REBILL. PAYROLL ADMIN.	82,411	CARE CENTERS, INC.		0	(82,411)	34
35	V	21	REBILL. PAYROLL CLERICAL	23,270	CARE CENTERS, INC.		0	(23,270)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 372,916			$ 0	$ * (372,916)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 3,805	$ 3,805	15
16	V	2	FOOD		CARE CENTERS, INC.		(809)	(809)	16
17	V	3	HOUSEKEEPING		CARE CENTERS, INC.		1,595	1,595	17
18	V	5	UTILITIES		CARE CENTERS, INC.		1,223	1,223	18
19	V	6	REPAIRS AND MAINT.		CARE CENTERS, INC.		10,011	10,011	19
20	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS, INC.		1,532	1,532	20
21	V	10	NURSING		CARE CENTERS, INC.		19,310	19,310	21
22	V	10A	THERAPY		CARE CENTERS, INC.		3,730	3,730	22
23	V	11	ACTIVITIES		CARE CENTERS, INC.		1,618	1,618	23
24	V	12	SOCIAL SERVICES		CARE CENTERS, INC.		1,426	1,426	24
25	V	15	EMP. BEN. - HEALTHCARE		CARE CENTERS, INC.		3,328	3,328	25
26	V	17	ADMINISTRATIVE		CARE CENTERS, INC.		25,747	25,747	26
27	V	19	PROFESSIONAL FEES		CARE CENTERS, INC.		6,779	6,779	27
28	V	20	DUES, SUBSCRIPTIONS		CARE CENTERS, INC.		995	995	28
29	V	21	CLERICAL AND GENERAL		CARE CENTERS, INC.		91,697	91,697	29
30	V	24	SEMINARS		CARE CENTERS, INC.		3,545	3,545	30
31	V	25	AUTO EXPENSE		CARE CENTERS, INC.		158	158	31
32	V	26	INSURANCE		CARE CENTERS, INC.		815	815	32
33	V	27	EMP. BEN. - GEN. ADMIN.		CARE CENTERS, INC.		13,547	13,547	33
34	V	30	DEPRECIATION		CARE CENTERS, INC.		8,555	8,555	34
35	V	32	INTEREST		CARE CENTERS, INC.		9,263	9,263	35
36	V	33	REAL ESTATE TAXES		CARE CENTERS, INC.		1,657	1,657	36
37	V	34	BUILDING RENT - UNRELATED		CARE CENTERS, INC.		3,168	3,168	37
38	V	35	EQUIPMENT RENTAL		CARE CENTERS, INC.		2,607	2,607	38
39	Total			$			$ 215,302	$ * 215,302	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 10,287	$ 10,287	15
16	V	15	EMP. BEN HEALTHCARE		CARE CENTERS, INC.		1,440	1,440	16
17	V	17	ADMINISTRATIVE		CARE CENTERS, INC.		82,411	82,411	17
18	V	27	EMP. BEN GEN. ADMIN.		CARE CENTERS, INC.		10,776	10,776	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 104,914	$ * 104,914	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 1,054	$ 1,054	15
16	V	2	FOOD		CARE CENTERS HEALTH SYSTEMS DIVISION		2,041	2,041	16
17	V	6	MAINTENANCE		CARE CENTERS HEALTH SYSTEMS DIVISION		9	9	17
18	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS HEALTH SYSTEMS DIVISION		100	100	18
19	V	10	NURSING		CARE CENTERS HEALTH SYSTEMS DIVISION		1	1	19
20	V	17	ADMINISTRATIVE		CARE CENTERS HEALTH SYSTEMS DIVISION		53	53	20
21	V	19	PROFESSIONAL FEES		CARE CENTERS HEALTH SYSTEMS DIVISION		16	16	21
22	V	20	DUES, FEES, SUB.		CARE CENTERS HEALTH SYSTEMS DIVISION		4	4	22
23	V	21	CLERICAL & GENERAL		CARE CENTERS HEALTH SYSTEMS DIVISION		53	53	23
24	V	24	SEMINARS		CARE CENTERS HEALTH SYSTEMS DIVISION		3	3	24
25	V	25	TRAVEL		CARE CENTERS HEALTH SYSTEMS DIVISION		92	92	25
26	V	32	INTEREST		CARE CENTERS HEALTH SYSTEMS DIVISION		3	3	26
27	V	35	RENT - EQUIPMENT & VEHICLES		CARE CENTERS HEALTH SYSTEMS DIVISION		5	5	27
28	V	39	ANCILLARY ENTERAL SUPPLIES		CARE CENTERS HEALTH SYSTEMS DIVISION		69	69	28
29	V	1	DIETARY SUPP	717	CARE CENTERS HEALTH SYSTEMS DIVISION		0	(717)	29
30	V	39	ANCILLARY SUPP	4,144	CARE CENTERS HEALTH SYSTEMS DIVISION		0	(4,144)	30
31	V	0							31
32	V	0							32
33	V	0							33
34	V	0							34
35	V	0							35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,861			$ 3,503	$ * (1,358)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.		CARE CENTERS, INC.		0		16
17	V	0							17
18	V	0							18
19	V	0							19
20	V	0							20
21	V	0							21
22	V	0							22
23	V	0							23
24	V	0							24
25	V	0							25
26	V	0							26
27	V	0							27
28	V	0							28
29	V	0							29
30	V	0							30
31	V	0							31
32	V	0							32
33	V	0							33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 23,726	$ 23,726	15
16	V									16
17	V									17
18	V									18
19	V	10	MEDICALSUPPLIES	28,226	XCEL MEDICAL SUPPLLY LLC			(28,226)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			$ 28,226			$ 23,726	$ * (4,501)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 61,401	$ 61,401	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	61,401				(61,401)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 61,401			$ 61,401	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	33%	See Attached	1.46	2%	Mgmt. Fees	$ 71,009	17-3	1
2	Noah Wolff	Owner	Administrative	33%	See Attached	14	35%	Mgmt. Fees	71,009	17-3	2
3	Mark Steinberg	Relative	Administrative	0.00	See Attached	1.49	3%	Alloc. Salary	1,317	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,335		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	44,910	$ 3,805	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		44,910	(809)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	44,910	1,595	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		44,910	1,223	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	44,910	10,011	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		44,910	1,532	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	44,910	19,310	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	44,910	3,730	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	44,910	1,618	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	44,910	1,426	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		44,910	3,328	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	44,910	25,747	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		44,910	6,779	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		44,910	995	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	44,910	91,697	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		44,910	3,545	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		44,910	158	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		44,910	815	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		44,910	13,547	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		44,910	8,555	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		44,910	9,263	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		44,910	1,657	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		44,910	3,168	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		44,910	2,607	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 215,302	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		10,287	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			1,440	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		82,411	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			10,776	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 104,914	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	4,861	1,054	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		4,861	2,041	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		4,861	9	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		4,861	100	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		4,861	1	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		4,861	53	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		4,861	16	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		4,861	4	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		4,861	53	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		4,861	3	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		4,861	92	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		4,861	3	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		4,861	5	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		4,861	69	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 3,503	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 23,726	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 23,726	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847)673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 61,401	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 61,401	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB Bank		X	Mortgage Loan	$31,975.00	10/10/99	$ 1,000,000	$ 984,535	9/2004	0.0825	$ 82,771	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Diawa Loan	X		Line of Credit				146,945			4,309	6
7												7
8												8
9	TOTAL Facility Related				$31,975.00		$ 1,000,000	$ 1,131,480			$ 87,080	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	CCI Allocation	X									9,263	11
12	Interest Income		X								(7,675)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,588	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 1,131,480			$ 88,668	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	131,496	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	135,423	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,927	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	140,454	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	6,757	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 461 For 19 94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	151,138	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	121,527	8
	1996	122,793	9
	1997	125,056	10
	1998	125,208	11
	1999	133,766	12

2000 Accrual is 1999 tax * 1.05. $133,766 * 1.05 = $140,454

Amount on line 2 includes CCI Allocation of $1,657

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 2,219 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	56,110	1962	$ 27,417	1
2	Related Party		1996	1,901	2
3	TOTALS	56,110		$ 29,318	3

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	134		1962	1962	$ 451,782	$		$	$	$ 339,532	4
5			1987	1987	1,493,264	50,341		47,405	(2,936)	571,154	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	1,435		20			1,435	9
10	Various			1976	4,663		20			4,663	10
11	Various			1977	2,336		20			2,336	11
12	Various			1978	765		20			765	12
13	Various			1980	33,145		20			33,145	13
14	Various			1982	2,378		20			2,292	14
15	Various			1983	45,375		20	1,815	1,815	30,896	15
16	Various			1984	21,344	909	20	853	(56)	13,153	16
17	Various			1985	14,833	742	20	742		11,130	17
18	Various			1986	16,300	685	20	815	130	11,410	18
19	Various			1988	41,219	694	20	1,662	968	21,122	19
20	Various			1989	3,324	106	20	166	60	1,879	20
21	Various			1990	8,400	267	20	420	153	4,235	21
22	Various			1991	34,006	1,081	20	1,702	621	16,660	22
23	Various			1992	8,695	276	20	435	159	3,634	23
24											24
25	PAGE 12-1 REP TOTALS				42,343	1,125		1,405	280	5,640	25
26											26
27											27
28											28
29											29
30											30
31	PAGE 12E TOTALS				128,599	6,879		4,037	(2,842)	4,279	31
32	PAGE 12D TOTALS				45,035	3,922		2,252	(1,670)	4,742	32
33	PAGE 12C TOTALS				125,376	3,044		6,269	3,225	15,059	33
34	PAGE 12B TOTALS				74,392	1,908		3,720	1,812	11,875	34
35	PAGE 12A TOTALS				232,215	6,544		11,618	5,074	60,892	35
36	TOTAL (lines 4 thru 35)				$ 2,831,224	$ 78,523		$ 85,316	$ 6,793	$ 1,171,928	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	11,679	110	20	585	475	4,495	9
10	Various			1994	29,410	684	20	1,472	788	9,642	10
11	Various			1995	118,494	3,040	20	5,927	2,887	31,477	11
12	PAINTING &DECORATING			1996	2,500	64	20	125	61	510	12
13	PLUMBING RENOV			1996	2,194	56	20	110	54	541	13
14	NEW MOTOR			1996	618	71	20	31	(40)	129	14
15	HVAC RENOV			1996	6,360	163	20	318	155	1,298	15
16	ELECTRICAL RENOV			1996	910	23	20	46	23	226	16
17	PLUMBING RENOV			1996	701	18	20	35	17	163	17
18	FENCE			1996	525	13	20	26	13	117	18
19	WATER HEATER RENOV			1996	1,980	51	20	99	48	446	19
20	HVAC RENOV			1996	1,094	28	20	55	27	238	20
21	WINDOWS			1996	41,300	1,059	20	2,065	1,006	8,432	21
22	PLUMBING RENOV			1996	1,374	35	20	69	34	345	22
23	MIXING VALUE			1996	1,246	143	20	62	(81)	295	23
24	NEW MOTOR			1996	572	65	20	29	(36)	123	24
25	BOOSTER HEATER			1996	941	109	20	47	(62)	196	25
26	DRAPES			1996	506	45	20	25	(20)	113	26
27	NEW MOTOR			1996	575	67	20	29	(38)	208	27
28	ALERT PANEL			1996	1,234	110	20	62	(48)	269	28
29	ALERT PANEL			1996	578	67	20	29	(38)	126	29
30	TRANSFORMER			1996	1,918	221	20	96	(125)	440	30
31	PUMP RENOV			1996	1,819	209	20	91	(118)	379	31
32	ELECTRICAL RENOV			1997	794	20	20	40	20	143	32
33	BLDG RENOVATION			1997	1,500	38	20	75	37	300	33
34	HVAC RENOV			1997	870	22	20	44	22	139	34
35	PAGING SYSTEM			1997	523	13	20	26	13	102	35
36	TOTAL (lines 4 thru 35)				$ 232,215	$ 6,544		$ 11,618	$ 5,074	$ 60,892	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING RENOV			1997	1,400	36	20	70	34	274	9
10	BOILER RENOV			1997	2,299	59	20	115	56	431	10
11	HVAC RENOVATION			1997	1,996	51	20	100	49	383	11
12	ELECTRICAL RENOV			1997	529	14	20	26	12	95	12
13	HVAC RENOVATION			1997	2,225	57	20	111	54	389	13
14	PLUMBING RENOV			1997	1,675	43	20	84	41	301	14
15	FENCE			1997	1,700	44	20	85	41	312	15
16	HVAC RENOVATION			1997	623	16	20	31	15	109	16
17	PAINTING & DEC			1997	700	18	20	35	17	140	17
18	NURSE CALL SYSTEM			1997	1,505	39	20	75	36	263	18
19	TRASH COMPACTOR			1997	3,191	82	20	160	78	560	19
20	ELECTRIC RENOV			1997	1,905	49	20	95	46	325	20
21	LANDSCAPING			1997	23,880	612	20	1,194	582	3,881	21
22	PAINTING & DEC			1997	1,526	39	20	76	37	247	22
23	FIRE ALARM SYSTEM			1997	690	18	20	35	17	114	23
24	HVAC RENOVATION			1997	1,047	27	20	52	25	182	24
25	BLDG RENOVATION			1997	1,161	30	20	58	28	189	25
26	HVAC RENOVATION			1997	1,574	40	20	79	39	316	26
27	PAINTING & DEC			1997	700	18	20	35	17	123	27
28	WALL COVERING			1998	3,173	81	20	159	78	424	28
29	LANDSCAPING			1998	1,147	29	20	57	28	147	29
30	DOORS			1998	3,976	102	20	199	97	531	30
31	PLASTER			1998	1,200	31	20	60	29	155	31
32	DRAPES			1998	6,552	168	20	328	160	929	32
33	PLUMBING RENOV.			1998	5,853	150	20	293	143	781	33
34	SEWER REPAIR			1998	745	19	20	37	18	96	34
35	FIRE SYS RENOV			1998	1,420	36	20	71	35	178	35
36	TOTAL (lines 4 thru 35)				$ 74,392	$ 1,908		$ 3,720	$ 1,812	$ 11,875	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SEWER LINE			1998	780	20	20	39	19	101	9
10	PAINTING			1998	746	19	20	37	18	96	10
11	HVAC RENOV			1998	6,273	161	20	314	153	811	11
12	ROOFING			1998	2,300	59	20	115	56	297	12
13	ASPHALT			1998	14,318	367	20	716	349	1,850	13
14	ART			1998			20				14
15	FIRE SYS.UPGRADE			1998	5,172	133	20	259	126	691	15
16	HVAC RENOV			1998	2,258	58	20	113	55	301	16
17	DOORS			1998	37,625	965	20	1,881	916	4,076	17
18	Painting & decoratin			1998	6,688		20	334	334	779	18
19	LAMINATE TOPS			1998	7,105	182	20	355	173	888	19
20	PLUMBING RENOV			1998	545	14	20	27	13	68	20
21	CARPETING			1998	5,250	135	20	263	128	636	21
22	WALL COVERING			1998	4,885	125	20	244	119	569	22
23	PLASTER			1998	750	19	20	38	19	89	23
24	FLUSH METAL DOORS			1998	4,660	119	20	233	114	485	24
25	BED SPREADS			1998			20				25
26	SPRINKLER HEADS			1998	1,420	36	20	71	35	148	26
27	PLUMBING RENOV			1998	800	21	20	40	19	117	27
28	WANDERER SYS			1998	5,804	149	20	290	141	701	28
29	HVAC RENOV			1998	1,120	29	20	56	27	154	29
30	SEAL COAT			1998	1,079	28	20	54	26	135	30
31	HVAC RENOV			1998	717	18	20	36	18	105	31
32	NURSE CALL SYS.			1998	1,905	49	20	95	46	277	32
33	PAINTING			1998	1,000	26	20	50	24	142	33
34	DRYWALL			1998	795	20	20	40	20	120	34
35	DRAPERIES			1998	11,381	292	20	569	277	1,423	35
36	TOTAL (lines 4 thru 35)				$ 125,376	$ 3,044		$ 6,269	$ 3,225	$ 15,059	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHTING			1998	921	24	20	46	22	130	9
10	DRAPES			1998	2,279	58	20	114	56	257	10
11	PHONE SYSTEM			1998	5,484	1,250	20	274	(976)	959	11
12	WALLCOVERING			1998	525	13	20	26	13	65	12
13	HINGES			1999	6,375	163	20	319	156	479	13
14	CW ENERGY SAVER			1999	590	15	20	30	15	60	14
15	UTILITY ROOM WORK			1999	6,087	156	20	304	148	608	15
16	TILES FOR LOUNGE			1999	5,625	144	20	281	137	562	16
17	FOUNTAINS			1999	839	22	20	42	20	84	17
18	VALUES			1999	710	18	20	36	18	72	18
19	FIRE ALARM REPAIR			1999	1,443	37	20	72	35	126	19
20	PAINT			1999	822	21	20	41	20	82	20
21	FABRIC			1999	722	19	20	36	17	48	21
22	FIRE ALARM REPAIR			1999	633	16	20	32	16	56	22
23	FLOWER PLATTING			1999	1,286	33	20	64	31	101	23
24	ART WORK			1999			20				24
25	NURSE CALL			1999	830	266	20	42	(224)	125	25
26	FIRE ALARM REPAIR			1999	2,048	53	20	102	49	179	26
27	DRAPES			1999	585	143	20	29	(114)	34	27
28	ALARM DETERRANT			1999	607	194	20	30	(164)	81	28
29	HOSES			1999	807	21	20	40	19	80	29
30	FANS			1999	612	196	20	31	(165)	67	30
31	CARPETING			1999	854	209	20	43	(166)	50	31
32	FANS			1999	1,074	344	20	54	(290)	108	32
33	FANS			1999	684	219	20	34	(185)	74	33
34	LOCK & DOOR HANDLES			1999	1,840	47	20	92	45	161	34
35	PLUMBING SUPPLIES			1999	753	241	20	38	(203)	94	35
36	TOTAL (lines 4 thru 35)				$ 45,035	$ 3,922		$ 2,252	$ (1,670)	$ 4,742	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FAUCET			1999	1,297	415	20	65	(350)	163	9
10	TRANSMITTER			1999	712	228	20	36	(192)	95	10
11	DRAPES			1999	1,843	47	20	92	45	115	11
12	VINYL LOUVER			1999	666	213	20	33	(180)	72	12
13	DOOR KNOB			1999	547	14	20	27	13	50	13
14	TUCKPOINTING			2000	14,500	140	20	302	162	302	14
15	CLOSET DOORS			2000	1,250	9	20	21	12	21	15
16	DOOR			2000	628	126	20	26	(100)	26	16
17	FUEL TANK			2000	1,133	8	20	19	11	19	17
18	PAINTING			2000	7,000	52	20	117	65	117	18
19	CLOSET DOORS			2000	1,500	11	20	25	14	25	19
20	CLOSET DOORS			2000	2,250	17	20	38	21	38	20
21	CLOSETS/DOORS			2000	6,717	1,344	20	392	(952)	392	21
22	HOOD SYSTEM			2000	685	137	20	12	(125)	12	22
23	PAINTING			2000	3,350	25	20	56	31	56	23
24	COMPRESSOR			2000	2,437	488	20	122	(366)	122	24
25	CLOSETS/DOORS			2000	560	112	20	33	(79)	33	25
26	SINK PROJECT			2000	891	12	20	26	14	26	26
27	DOOR CLOSURE			2000	3,250	650	20	190	(460)	190	27
28	NEW ROOF			2000	58,000	805	20	1,692	887	1,692	28
29	DOOR FRAME			2000	1,200	240	20	90	(150)	90	29
30	CUBICLE CURTAINS			2000	2,688	538	20	269	(269)	269	30
31	FIRE ALARM CABINET			2000	1,090	218	20	27	(191)	27	31
32	PAINTING			2000	9,000	48	20	113	65	113	32
33	CONTROL HEAD			2000	523	5	20	11	6	11	33
34	SWITCH SYSTEM			2000	4,882	977	20	203	(774)	203	34
35											35
36	TOTAL (lines 4 thru 35)				$ 128,599	$ 6,879		$ 4,037	$ (2,842)	$ 4,279	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			Alloc - CCI	1996	$ 33,637	$ 862	35	$ 961	$ 99	$ 3,924	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CCI ALLOCATION			2000	41	1	20	2	1	2	9
10	CCI ALLOCATION			1999	602	15	20	30	15	57	10
11	CCI ALLOCATION			1998	248	6	20	12	6	33	11
12	CCI ALLOCATION			1997	3,528	81	20	195	114	943	12
13	CCI ALLOCATION			1996	3,878	51	20	187	136	641	13
14	CCI ALLOCATION			1994		11			(11)		14
15	CCI ALLOCATION			1993		3			(3)		15
16	CCI ALLOCATION - INDIANA			1997	409	95	20	18	(77)	40	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 42,343	$ 1,125		$ 1,405	$ 280	$ 5,640	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 397,386	$ 39,269	$ 33,067	$ (6,202)		$ 214,074	37
38	Current Year Purchases	96,914	19,213	4,092	(15,121)		4,092	38
39	Fully Depreciated Assets	258,252		2,441	2,441		258,252	39
40								40
41	TOTALS	$ 752,552	$ 58,482	$ 39,600	$ (18,882)		$ 476,418	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	CCI Allocation			$ 15,977	$ 3,461	$ 2,465	$ (996)	10	$ 5,531	42
43										43
44	Overstatement of Depreciation prior period				(4,138)		4,138			44
45										45
46	TOTALS			$ 15,977	$ (677)	$ 2,465	$ 3,142		$ 5,531	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	3,629,071	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	136,328	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	127,381	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	(8,947)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,653,877	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CONCORD EXTENDED CARE
0026914
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
CONCORD EXTENDED CARE	368,860	35,578	29,983	(5,595)	200,850
CARE CENTERS, INC.	28,526	3,691	3,084	(607)	13,224
TOTALS	397,386	39,269	33,067	(6,202)	214,074
LINE 29: CURRENT YEAR					
CONCORD EXTENDED CARE	95,307	18,937	4,055	(14,882)	4,055
CARE CENTERS, INC.	1,607	276	37	(239)	37
TOTALS	96,914	19,213	4,092	(15,121)	4,092
LINE 30: FULLY DEPRECIATED					
CONCORD EXTENDED CARE	258,252		2,441	2,441	258,252
CARE CENTERS, INC.					
TOTALS	258,252		2,441	2,441	258,252
TOTALS (Should Tie to Totals on Page 13)					
CONCORD EXTENDED CARE	722,419	54,515	36,479	(18,036)	463,157
CARE CENTERS, INC.	30,133	3,967	3,121	(846)	13,261
TOTALS	752,552	58,482	39,600	(18,882)	476,418

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated to CCI							5
6					3,168			6
7	TOTAL				$ 3,168 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 7,472 Description: Copier - $1943, Time Clock - $2543, Postage Meter - $379, CCI Allocation - $2,607
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 70,687	$		$ 70,687	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,816			19,816	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			80,155			80,155	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				43,033		43,033	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-1					37,680		37,680	13
14	TOTAL			$		$ 170,658	$ 80,713		$ 251,371	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	19,229
2	Complex Medical Equip	7,639
3	Oxygen	1,009
4	Laboratory Services	2,831
5	Radiology	1,962
6	Ambulance	350
7	Respiratory Supplies	281
8	Enteral Supplies	4,379
9		
10		
		37,680

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,212	$	1
2	Cash-Patient Deposits	32,576		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	669,973		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	110,309		6
7	Other Prepaid Expenses	4,145		7
8	Accounts Receivable (owners or related parties)	40,456		8
9	Other(specify): See supplemental schedule	45,273		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 914,944	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,417		13
14	Buildings, at Historical Cost	2,069,821		14
15	Leasehold Improvements, at Historical Cos	764,858		15
16	Equipment, at Historical Cost	788,955		16
17	Accumulated Depreciation (book methods)	(1,799,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	6,230		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,857,361	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,772,305	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 367,975	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,478		28
29	Short-Term Notes Payable	146,945		29
30	Accrued Salaries Payable	124,079		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,443		31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,454		32
33	Accrued Interest Payable	11,560		33
34	Deferred Compensation	1,272		34
35	Federal and State Income Taxes	9,950		35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 843,156	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	984,535		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 984,535	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,827,691	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 944,614	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,772,305	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number CONCORD EXTENDED CARE **#** 0026914 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	40,273	
Due from Employees	5,000	
	45,273	

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Finance Costs (Net of Accum Amortization)	6,230	
	6,230	

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 966,059	1
2	Restatements (describe):		2
3	Schedule attached	291	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 966,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	506,037	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(527,773)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (21,736)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 944,614	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	CONCORD EXTENDED CARE	#	0026914	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger			966,350
Adjustments:			
			-
			-
			-
Restatement:	Adjustment to Amortization per schedule		(291)
Total adjustments			(291)
Balance - Beginning of Year			966,059
Equity(Deficit) from Page 17 Col 1			944,614
Related Party			
Equity(Deficit)		0	
Income		0	
			-
Combined Equity - End of Year			944,614

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,938,439	1
2	Discounts and Allowances for all Levels	(804,195)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,134,244	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	773,165	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 773,165	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,880	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,492	19
20	Radiology and X-Ray	1,550	20
21	Other Medical Services	90,528	21
22	Laundry	7,848	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 173,298	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,675	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,675	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	478	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 478	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,088,860	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	899,352	31
32	Health Care	1,861,869	32
33	General Administration	1,132,006	33
	B. Capital Expense		
34	Ownership	364,660	34
	C. Ancillary Expense		
35	Special Cost Centers	251,370	35
36	Provider Participation Fee	73,566	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,582,823	40
41	**Income before Income Taxes (line 30 minus line 40)****	506,037	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 506,037	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Misc. Income - Jury Duty (Adj out Page 5)	17
2	Real Estate Tax Rebate - 1994	461
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	478

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,464	1,608	$ 41,004	$ 25.50	1
2	Assistant Director of Nursing	2,334	2,451	50,672	20.67	2
3	Registered Nurses	9,002	10,732	214,709	20.01	3
4	Licensed Practical Nurses	18,939	21,169	384,373	18.16	4
5	Nurse Aides & Orderlies	71,302	81,187	719,911	8.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,489	4,297	47,737	11.11	8
9	Activity Director	1,624	1,840	21,140	11.49	9
10	Activity Assistants	7,029	7,693	54,541	7.09	10
11	Social Service Workers	3,346	3,923	48,511	12.37	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,330	31,424	13.49	13
14	Head Cook	4,772	5,310	44,906	8.46	14
15	Cook Helpers/Assistants	12,184	13,617	102,051	7.49	15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,175	38,513	17.71	17
18	Housekeepers	22,668	25,032	198,036	7.91	18
19	Laundry	7,535	8,658	73,907	8.54	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,794	6,766	92,685	13.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,776	2,013	18,716	9.30	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	177,282	200,801	$ 2,182,836 *	$ 10.87	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	337	$ 13,614	1-3	35
36	Medical Director	Monthly	5,171	9-3	36
37	Medical Records Consultant	Monthly	3,784	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,755	10-3	39
40	Physical Therapy Consultant	26	1,288	10A-3	40
41	Occupational Therapy Consultant	21	1,415	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	388	10A-3	43
44	Activity Consultant	52	2,296	11-3	44
45	Social Service Consultant	Monthly	1,152	12-3	45
46	Other(specify)				46
47	CCI ALLOCATION (see attached)		26,260	various	47
48					48
49	TOTAL (lines 35 - 48)	444	$ 59,123		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	232	$ 9,846	10-3	50
51	Licensed Practical Nurses	1,325	37,507	10-3	51
52	Nurse Aides	5,498	105,191	10-3	52
53	TOTAL (lines 50 - 52)	7,055	$ 152,544		53

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Administrator's salary paid through			
Care Centers Inc.			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Eric Rothner Management fees	$ 71,009
Noah Wolff Management fees	71,009
CCI Administrative Payroll	82,411
TOTAL (agree to Schedule V, line 17, col. 3)	$ 224,429
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached Schedule	Legal Services	$ 48,076
Frost, Ruttenberg & Rothblatt	Accounting Svcs	10,200
Care Centers, Inc.	Accounting Svcs	15,000
Threshold Data	Data Processing	190
Alpha Data Svcs.	Data Processing	3,863
Maxsource	Data Processing	1,100
Sourcetech	Data Processing	1,381
Integrated Inventory	Data Processing	115
Care Centers, Inc.	Data Processing	4,788
Personnel Planners, Inc	Unemployment Tax Consultant	1,003
See Attached Schedule	Other Consultants	143,130
Care Centers, Inc.	Bookkeeping Services	27,132
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 255,978

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,112
Unemployment Compensation Insurance	24,317
FICA Taxes	162,815
Employee Health Insurance	39,626
Employee Meals	16,397
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	518
Pension Expense	3,818
Employee Benefits	7,931
TOTAL (agree to Schedule V, line 22, col.8)	$ 315,534

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	7,403
Health Care Worker Background Check	
(Indicate # of checks performed 112)	1,348
Licenses	2,319
Dues	3,109
Advertising & Promotion	23,468
Yellow Pages Advertising	1,934
CCI Allocation	995
Less: Public Relations Expense	( )
Non-allowable advertising	(23,468)
Yellow page advertising	(1,934)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,374

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,647
Allocated from CCI	3,545
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,192

**See instructions.

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CONCORD EXTENDED CARE # 0026914 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Council on LTC - $3076**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,557** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **73,566**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **16,397** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw